Updated 03/2022

KAI CAMP/CLINIC CONFIDENTIAL MEDICAL RECORD

Name of Camp: _____

This completed form must accompany the camper on their first health center visit. It is essential that consent for treatment of a minor is signed by a parent/guardian.

Camper's Name: _____ Sex: _____

SSN: _____ Birth Date: _____

Parent/Guardian Name: _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Person to notify in case of emergency, if other than above:

Name: _____

Home Phone: _____ Cell Phone: _____

Address: _____

_____

Name of Family Physician: _____ Phone: _____

1. **Does camper have any significant illness or disability?** □ YES □ NO
If yes, please explain: _____

2. **Please check if camper has or has had any of the following:**
□ asthma □ chicken pox □ diabetes □ epilepsy □ kidney problems
□ polio □ rheumatic fever □ tuberculosis
□ other _____

3. **Has camper had any other significant illnesses, injuries, or surgeries?** □ YES □ NO
If yes, please explain: _____

4. **What routine medications & their dosages and time does the camper take?**
_____

5. **Date of last tetanus/diphtheria**: _____
Date of last MMR: _____

6. **Does camper have any allergies, including to any medications?** □ YES □ NO
If yes, please list:
_____
_____

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HEALTH INSURANCE BILLING INFORMATION

Insurance Company: _____ I.D. #: _____
Group #: _____

Claim Address: _____

Name of Policyholder: _____ Policyholder Date of Birth: _____

Address of Policyholder: _____

I hereby authorize Student Health Services to disclose to the above named insurance company, information from the camper's medical record as needed in presenting my claim for benefits.

_____ _____
Camper Signature Date

_____ _____
Parent/Guardian Signature Date

CONSENT FOR TREATMENT OF A MINOR

I hereby give my consent for treatment of:

_____
Last Name First Middle Date

This authorization covers any procedure, which may be deemed advisable by the attending staff physician.

_____
Parent/Guardian Signature Relationship to Camper Date